Elk Grove Smile Center
Family, Cosmetic & Implant Dentistry
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WELCOME! PLEASE INTRODUCE YOURSELF

Name:_____ **Birth Date:** ___/___/___ **Age:**___ **Sex:**___ **SSN:**____-____-____

Home Address: _____
Street City State Zip

Home Phone: (_____)_____-____ **Cell Phone:** (_____)_____ **Email Address:** _____

Preferred Method of Contact to Confirm Dental Appointments: Phone___ Email___ Text____

How did you hear about us: Google Search____ YELP____ Bing Search____ Insurance List____ Facebook____ Postcard ____

Patient Referral (list Patient's name)_____ Other_____

Employer: _____ **Occupation:** _____ **Work Phone:** (_____)_____

Married: Yes___ No___ **Spouse's Name:** _____ **Birth Date:** ___/___/___ **Sex:**___ **SSN:**____-____-____

Person Responsible for Account: _____

In Case of Emergency, please contact: _____ **Phone:** (_____)_____

DENTAL INSURANCE

Insured Person's Name: _____ **Birth Date:** ___/___/___ **SSN:**____-____-____

Name of Insurance Company: _____ **Subscriber ID or Member ID:**_____

Address:_____ **Group or Policy #**_____
Street City State Zip

Does your Spouse have separate dental insurance: Yes___ No___ **If Yes, does this Insurance Cover You Also:** Yes___ No___

Secondary Insured Person's Name: _____

Name of Insurance Company: _____

Address:_____ **Group or Policy #**_____
Street City State Zip

Our office will be glad to fill out and submit your insurance forms as a courtesy to you. However, it is the ultimate responsibility of the patient to pay for this account.

- I give my permission to you to call me to discuss matters related to this form.
- We kindly request that ***at least 48 hours*** advance notice be given to cancel your appointment.
- I have read the above conditions and I agree with them.

Signature: _____ **Date:** _____

DENTAL HISTORY

Previous Dentist: _____ **Phone:** (_____)_____

Date of Last Dental Visit (exam or treatment): _____ **Date of Last X-rays:** _____

Have you ever been treated for any of the following:

Endodontics (root canals) ____
Orthodontics (braces) ____
Periodontics (gum surgery) ____
Bridges or Crowns ____
Dentures/Partial Dentures ____
Oral Surgery (extractions) ____
Implants ____
Cosmetic Dentistry (whitening, veneers, etc) ____

Have you ever had an Injury or Trauma to the Face or Jaw: _____

Have you ever had TMJ (jaw joint) problems/clicking/tenderness: ____ **Last Time you had this issue**: _____

Are you currently having any problems with any of the following:

Temperature Sensitivity (hot/cold) ____
Pressure Sensitivity (on biting or chewing) ____
Tender or Bleeding Gums ____
Snoring ____
Bad Breath (halitosis) ____
Food Impaction ____
Clenching/Grinding ____
Other _____

MEDICAL HISTORY

Name of Physician or Clinic: _____ **Phone:** (_____)_____

How would you describe your general health: Good____ Fair ____ Poor ____

When did you last see your Physician: _____ **For what Condition:** _____

Have you had a major illness or been hospitalized within the last 5 years? Yes___ No___ **Explain:**_____

Please list any medications or drugs you are currently taking: _____

_____

Please check if you are sensitive to or had a reaction to the following:

Penicillin ____
Other Antibiotics ____
Sulfa Drugs ____
Other: _____

Novocaine/Lidocaine (Local anesthetic) ____
Codeine ____
Barbiturates (sleeping pills, sedatives) ____

Aspirin ____
Demerol ____
Latex ____

Do you Smoke or use Tobacco? Yes ___ No___ **How long and how much per day?** _____

Have you ever been told you need to pre-medicate for a dental appointment? Yes___ No___

Have you ever had any of the following:

Abnormal Blood Pressure (High/Low)……..……Yes No
HIV or AIDS……..…Yes No
Allergies (Hay fever, etc)……...Yes No
Anemia……..…Yes No
Angina (chest pains)…… …..……...…Yes No
Pacemaker or Artifical Heart Valve……..……Yes No
Arthritis……..…Yes No
Hepatitis, Jaundice, Liver Disease…...…..……Yes No
Respiratory Condition (TB, Asthma, Emphysema…Yes No
Joint Replacement (Hip, Knee, etc)……...……Yes No
Skin Disease…….……..……Yes No
Congenital Heart Defects……..…….……Yes No
Epilepsy/ Seizures……..……Yes No
Ulcers……..…Yes No
Venereal Disease (Syphyilis, Gonorrhea)…..……Yes No

Excessive Bleeding…..……..…Yes No
Eye Diseases (glaucoma, cataracts) ……Yes No
Rheumatic Fever or Heart Disease……Yes No
Heart murmur……Yes No
Stroke……Yes No
Severe or Frequent Headaches……..……Yes No
Herpes, Cold Sores, Fever Blisters……Yes No
Blood Transfusions…….……..…Yes No
Cancer, Tumors, Malignancies…....……Yes No
Kidney Disease or Disorder……...……Yes No
Thyroid Condition (hyper/hypo)……Yes No
Diabetes……..……Yes No
Psychiatric Treatment…….……Yes No
Heart Surgery…….....…Yes No
Parkinson's Disease……Yes No

Is there any other information about your health we should know?_____

WOMEN ONLY: Are you pregnant? Yes____ No____ **Expected Delivery Date:** _____
Are you taking Oral Contraceptives? Yes____ No____

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

DOCTOR SIGNATURE: _____ **DATE:** _____

CUSTOMIZING YOUR TREATMENT

I am most interested in:

___ Cosmetic Options
___ Whitening
___ Implants
___ Maintaining General Oral Health
___ Invisalign (Clear Braces)
___ Dentures
___ Children's Dentistry
___ Controlling Gum Disease
Other: _____

Please share your Hobbies or Interests with us: _____

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us **at least 48 hours** notice. This courtesy makes it possible to give your reserved room to another patient who may need it.

There is a charge of $50 for not showing up for scheduled appointments without giving at least 48 hours notice.

Repeated cancellations or missed appointments will result in loss of appointment privileges; a $50 non-refundable fee will be required to secure future appointment times.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Financial Policy

Payment is due at time of service on the day the procedure is started. Payment plans can be set up, but must be set up in advance.

Patient's with insurance: patient's estimated copay is due at time of service and the rest will be billed to the insurance company. Any remaining balance will be the patient's responsibility.

I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.

If sent to collections, I agree to pay all related fees and court costs. A 25% fee will be added to any account sent to collections. We reserve the right to send any patient account to collections for any balance 90 days past due.

Patient/Guardian Signature _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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